Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS COST CONTAINMENT INC
102 EAST MAIN
ALICE TEXAS 78333

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-2700-01

MFDR Date Received
April 8, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is regards to the workers' compensation claim on the above mentioned patient. We have tried sending this claim for payment twice, the original claim then a reconsideration sent in October 2010, and as of yet we have not received a response."

Amount in Dispute: $268.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the insurance carrier's representative box number 19 assigned to Flahive, Ogden & Latson on April 11, 2011. The DWC060 was picked up by Gordon Clayton on April 13, 2011. An audit will be conducted with the information contained in the dispute at the time of the review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2010	99203, 99080-73, L1820, A6402 and E0230	$268.70	$264.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out the guidelines for completing the Work Status Report.
4. The requestor did not submit copies of EOBS with the DWC060 request.

Issues

1. Did the requestor submit documentation to support the billing of the CPT code 99203 and HCPCS codes L1820, A6402, and E0230?
2. Did the requestor submit documentation to support the billing of CPT code 99080-73?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor disputes non-payment of CPT codes 99203, 99080-73, L1820, A6402, and E0230 rendered on April 28, 2010.

   CPT code 99203 is defined as “Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.”

   HCPCS Code L1820 is defined as “Knee orthotic, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment.”

   HCPCS Code A6402 is defined as “Gauze, nonimpregnated, sterile, pad size 16 sq in or less, without adhesive border, each dressing.”

   HCPCS Code E0230 is defined as “Ice cap or collar.”

   Review of the documentation submitted supports that the services billed were rendered; as a result the disputed services will be reviewed according to the applicable guidelines.

2. Per 28 Texas Administrative Code §129.5 “(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section..."

   The requestor submitted a copy of the Work Status Report completed in accordance with the division requirements set out in 28 Texas Administrative Code §129.5. As a result, the requestor is entitled to $15.00 for CPT code 99080-73 rendered on April 28, 2010.

3. Per 28 Texas Administrative Code §134.203 “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.”

   The MAR reimbursement for CPT code 99203 is $160.20, the requestor seeks $131.04, therefore this amount is recommended.

   Per 28 Texas Administrative Code §134.203 “(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS."

The MAR reimbursement for HCPCS Code L1820 is $152.11, the requestor seeks $109.66, and therefore this amount is recommended.

The MAR reimbursement for HCPCS Code A6402 is $0.16, this amount is recommended.

The MAR reimbursement for HCPCS Code E0230 is $11.13, the requestor seeks $8.50, and therefore this amount is recommended.

Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $264.36.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $264.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $264.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 27, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.